Child Safeguarding Practice Review

Child YS

Independent Reviewer: Sue Walters

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This report is strictly confidential. It must not be shared without the agreement of Sandwell Children's Safeguarding Partnership (SCSP) and Dudley Safeguarding People Partnership (DSPP). The disclosure of information (beyond that which is agreed) will be considered as a breach of the confidentiality of the children and agencies involved.

Introduction

1. This review considers systems and practice between partner agencies in the Sandwell and Dudley areas. The primary purpose of this review is to learn lessons and to use the learning to improve and sustain change.
2. It is important to note that prior to the incident, this family were not known to Children's Social Care services in Sandwell. Therefore, references to specific learning for Children's Services, and additionally schools, are pertinent for services in Dudley as this is where the family resided. However, agencies during this review agreed that some of the learning was applicable for both areas and agreed joint recommendations.
3. The family only became known to Sandwell Children's Trust following the serious attack on YS and took appropriate actions to assess the situation and safeguard both YS and twin sibling. Sandwell Children's Trust are the providers of Children's Social Care services in Sandwell.
4. The learning review takes into account the potential for hindsight bias. Hindsight, as in actions that should have been taken in the time leading up to an incident, can seem obvious because all the facts become clear after the event. This tends towards a focus upon blaming staff and professionals closest in time to the incident.
5. An Appreciative Inquiry model is used in order to understand what has happened, within a framework that is participative, collaborative, embraces professional curiosity and challenge, and focuses on what works well and what is valued.
6. The learning identified is in relation to:

    - The importance of being trauma aware and trauma informed
    - Impact of domestic abuse
    - Professional curiosity
    - Creating a safe space for multi-agency reflection
    - Cross-border information sharing processes
    - Cultural awareness and assumptions

Process

7. The Child Safeguarding Practice Review (CSPR) was conducted in accordance with the requirements set out in:

- The Children Act 2004[1] (as amended by the Children and Social Work Act 2017[2])
- Working Together 2018[3] (amended 2020)
- Sandwell Children's Safeguarding Policy and Procedures
- West Midlands Safeguarding Procedures

8. In respect of the information considered, personal family details will only be disclosed where it is essential to the learning established during the review.
9. An independent lead reviewer[4] was commissioned, facilitated learning events[5] and has spoken with the family and produced this report.
10. This review used a 'systems approach' via an appreciative enquiry model. Key themes were identified during the Rapid Review and these were then explored within two learning events. The event focussed upon identifying the emerging learning and translating this into system learning and practice improvement.

Brief overview

11. The review will refer to the following persons:

- YS is the subject child
- Twin sibling of subject child
- Mother of the subject child, twin siblings and 3 half siblings
- Father of the subject child and twin sibling
- 3 half siblings of the subject child born of the same mother
- Mother's ex-partner and father of the 3 half siblings

12. Child YS was seven months old when police were called to the home in Sandwell and witnessed Child YS being assaulted by father. The mother had also suffered serious injuries in the same attack and required hospitalisation. Child YS was in a critical condition with life threatening injuries.
13. Child YS is a twin but the sibling was not in the home at the time of the incident and was in the care of paternal grandparents. Father had obtained the property in Sandwell where the incident took place one month prior to the incident. Agencies in Dudley and Sandwell did not know this until after the serious incident. It is thought that mother and Child YS were dividing their time between maternal grandparents' house in Dudley and father's new address in Sandwell.
14. Up until the incident it was assumed that mother, Child YS and twin were living with maternal grandparents, maternal aunts and cousins. There had been no change of

[1] http://www.legislation.gov.uk/ukpga/2004/31/contents
[2] www.legislation.gov.uk/ukpga/2017/16/contents/enacted
[3] https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

address provided by the mother or recorded for Child YS and twin. It is thought that the address was registered in the father's name.

15. Father had a previous episode of mental ill health in 2015 which featured aggression and paranoia towards his mother and siblings. There had been previous cannabis misuse, possession of a knife and multiple arrests. Father had resided in Sandwell throughout his life.
16. Child YS and twin had three older maternal half siblings who lived with maternal relatives. The maternal half-siblings had previously been on a Child Protection Plan due to domestic abuse perpetrated by their father which discontinued when the relationship ended and their father left the area. The marriage was an arranged Islamic marriage in Pakistan – the domestic abuse started immediately and continued when they returned to England.
17. The maternal half siblings of Child YS continue to display emotional and behavioural concerns which have resulted in safeguarding interventions historically in Dudley.

Analysis and identification of learning

18. The learning in this review includes the three maternal half siblings as well as Child YS and twin. It became apparent during the learning events that there was concern about the welfare of half siblings and their lived experience.
19. In addition, the importance of adopting a trauma informed approach is key learning for both partnerships, as is understanding the impact and consequences of trauma.
20. The learning is informed by a conversation with mother who disclosed that she had experienced domestic abuse by the father of Child YS – until the assault of both Child YS and mother, no previous domestic abuse incidents between mother and father were known.

Impact of domestic abuse

21. The mother experienced domestic abuse in her first marriage which resulted in the three half siblings being made the subjects of Child Protection Plans in Dudley, which terminated in 2011 when the domestic abuse and the relationship ended. Since this time, the three half siblings have displayed various behavioural issues, some of which have led to exclusions from school and referrals to CAMHS. Concerns were last shared with Dudley Children's Services in 2016 via a referral when one half sibling verbalised concerns and there was a potential lack of emotional support from parents. This was explored via an assessment which led to an offer of support from Early Help.
22. Health services in Dudley, in contact with mother during pregnancy and after the birth of the twins, did not document evidence of domestic abuse in this relationship. Routine

inquiry questions for domestic abuse were asked by both the midwives and health visitor and the mother answered negatively.

23. The main details regarding father of Child YS were held by his GP in Sandwell but his details were given as the emergency contact on maternity records in Dudley, and not named as the father. Father attended induction of labour although he was not present at the birth by caesarean section. Mother referred to herself as a single parent at the primary birth visit with the health visitor.
24. There were indicators that there were some difficulties in the relationship between Child YS' parents as evidenced by the father's comments in a consultation with his GP. Father requested help for anxiety, stating that he had married, and his wife was three months' pregnant with twins. He informed his GP that there were relationship problems, and his wife was spending more time at her parents' home. It appears there was no attempt to gain further information regarding pregnant mother in order to share this with other health services. The GP referred him to the IAPT[6] service however father did not attend the offered appointment.
25. In addition, the school had been informed that there was tension with paternal grandparents about the relationship between mother and father.
26. Over several years mother had experienced a number of health issues such as gynaecological/urinary problems and long-standing anxiety and depression. There are long-term detrimental impacts of domestic abuse on health. This can include urinary tract infections, gynaecological problems, headaches, anxiety and depression[7].
27. When 10 weeks pregnant with the twins, mother visited her GP in Dudley with chronic anxiety. She informed her GP that she was feeling anxious, and the father was not involved with the pregnancy. This information was not shared with the midwife or health visitor.
28. After the birth of Child YS and twin, the mother reported that she spoke about her loss of appetite, sleeping problems and aches and pains with the health visitor and received advice.
29. In conversations with professionals, the mother described her first husband as 'not nice to them' and that there had been social care involvement because of his treatment of the children and domestic abuse. At the practitioner events the responses given by the mother to professionals were described as 'vague'. The disclosure of

[6] IAPT Improving access to psychological therapies

[7] Cry For Health 2016

previous social care involvement did not result in further probing or exploration with Children's Services. Midwifery records report mother's longstanding anxiety and previous prescriptions for antidepressants. On at least two occasions the mother reported feelings of anxiety to midwives and was offered the option of a referral to the Perinatal Mental Health service. This history should have resulted in a referral to the Unborn Baby Network in Dudley. Additionally, mother pointed out in her conversation with the author that although she had three older children, a twin pregnancy was a new experience.

30. Mother of Child YS has spoken with the author about experiencing verbal abuse from the twins' father during her pregnancy. Following the birth, she alleged he would punch and spit at her and she was not allowed to go to the gym and felt trapped. This was allegedly observed by a neighbour as well as the paternal grandparents of Child YS however no reports of concern were submitted by these parties.
31. When mother of Child YS was 6 or 7 months pregnant it is alleged by her that the father was arrested and was taking cannabis. According to police reports he was arrested and convicted at this time for driving while unfit. There is no indication that he was asked about family details or children which could have led to information being shared with Dudley Children's Services had the existence of the twins been disclosed.
32. A complex picture emerges in which no one professional was able to piece together information to enable a conversation with the other about domestic abuse. The mother's potential underlying trauma due to previous domestic abuse and the reasons for ongoing anxiety are missed. She repeatedly replied no to the routine enquiry domestic abuse questions asked by maternity services in Dudley and did not want to talk about the twins' father, preferring to say that she was a single parent. This was in spite of the fact that he was named as an emergency contact and attended induction of labour. Information was taken at face value without any professional curiosity.
33. The experience of trauma affects how people approach services. In this case, the mother said that she did not tell the midwife, health visitor or GP about what was happening to her because she was afraid that paternal grandparents would find out. We know from the work of Karen Treisman[8] that being trauma informed is about relationships and connection. In a busy clinic setting it is not easy to build trusting relationships and yet this is at the heart of the way health professionals work.

[8] Karen Treisman 2018

34. There was only one appointment when the mother was not alone. Routine enquiry questions were asked at all appointments when she was alone. Even so, she did not feel able to disclose abuse.

Learning

- The workforce needs to understand the impact of trauma and be equipped with the knowledge, skills, and behaviours specific to their role in relation to becoming more trauma-informed in practice.
- Routine enquiry is about asking direct questions about domestic abuse and yet it is more than a checklist. Questions need to be asked sensitively yet confidently. Maternity and health visiting services in both areas should review and evaluate the use of routine enquiry, seeking advice from the IDVA service.
- Understanding that some health conditions may be linked to the long-term impacts of domestic abuse is important to prompt practitioners to probe and provide opportunities for women to safely disclose.
- The mother's GP Practice is now part of the IRIS[9] programme with associated training.
- Understanding the way in which different faith communities perceive domestic abuse and the difficulty in speaking openly is important. In this instance, the mother did not think that she could trust anyone in her community and was afraid that the paternal grandparents of Child YS would find out if she sought help. She described them as being unhappy that she had been previously married and had 'baggage'.
- If the midwives had reviewed the GP records for mother and maternal half siblings and connected these with mother's anxiety, this might have led to a referral to the Unborn Baby Network.

Professional Curiosity and Reflection

35. This is a complex family situation and separate pieces of the family jigsaw were held by only a few services. The main agencies in contact with mother and father were health services and schools for maternal half siblings. There was no full picture of family circumstances, and limited information about the father of Child YS and twin.
36. Practitioners at the learning events used words such as 'secretive' to describe mother and the extended family. There was a sense that the family may have acted to deflect professional involvement. These are powerful assumptions to be explored in a supervision process.

[9] IRIS is a specialist domestic violence and abuse (DVA) training, support and referral programme for General Practices that has been positively evaluated in a randomised controlled trial.

37. Sidebotham et al[10] have highlighted the importance of supervision in challenging the use of terms such as ‘non-engagement,’ 'hard to reach,’ ‘resistant,’ ‘difficult’ and in this case ‘secretive’. This can lead to assumptions and prevent the practitioner from developing a trauma-based, open approach and exercising respectful uncertainty. It needs further exploration in supervision.
38. School had increasing concerns about the maternal half siblings and stated that they were not aware that the mother was pregnant with Child YS and twin. However, the mother has stated that the teachers were aware of her pregnancy.
39. Schools for the maternal half siblings had started to complete a genogram to try to understand family connections. They had a growing sense of unease but this did not result in a multiagency meeting, a referral to social care or a discussion with family members.
40. Genograms are a visual family mapping tool which allows practitioners to map a family history through at least three generations. Genograms at a basic level show family relationships in terms of parentage and birth order across the generations, similar to a family tree. However, they should go beyond this more superficial information to capture what is known about family functioning and processes as a cultural genogram.
41. In this case a genogram was helpful but we do not know if it focussed on the more in-depth approach described above. Involvement of the family as well as other key agencies would have opened up a wider discussion including mother’s pregnancy.
42. Mother had informed her GP that one of her older children lived with a maternal relative – this did not lead to any further enquiries.
43. Father had a known episode of mental ill health including aggression and paranoia and was in possession of a knife which led to a 24 hour voluntary assessment in a mental health facility. There were also concerns about cannabis misuse. This information was contained in the father’s GP records.
44. Midwifery and health visiting thought that mother was a single parent pregnant with twins and was living with her extended family. Mother had reported to both services that there had been previous social care involvement which should have prompted further exploration and at the very least a conversation with Children’s Services, and possibly a referral to the Unborn Baby Network.

[10] The fifth consecutive analysis of serious case reviews in England undertaken by the same research team dating back to reviews from 2003-2005. The study considers a total of 293 SCRs relating to incidents which occurred in the period 1 April 2011-31 March 2014.

45. The health visiting primary birth review for the twins had taken place at the maternal grandparents' home. Again, mother reported that she was a single parent and did not want to give the father's details, but had given his details as next of kin in the maternity records.
46. There was no curiosity about the family dynamics and an assumption that living in a large extended family environment was normal for Asian families who provided family support. No history was taken about the older children or contact made with the school or school nurse.
47. No agency knew that Child YS and mother were living with father in Sandwell until after the incident, with Child YS appearing to move between two addresses. Mother did not change her or the twins' addresses on GP or maternity records.
48. The primary birth visit and follow up contact was undertaken before the impact of COVID-19 on service delivery. An assessment was undertaken at the beginning of COVID-19 and the family remained on the universal pathway resulting in less face-to-face contact for families and children.
49. ***'Knowing but not knowing'*** [11] relates to having a sense that something is not right, such as the unease in this case which was felt by schools in particular. This should have prompted a wider discussion with partners however it led to an insular internally focussed response which perpetuated the sense of frustration and, potentially, lack of progress for the older children. It also meant that a valuable opportunity was lost to understand the wider family. This should be explored in supervision processes and professional multiagency discussions. The older children referred to witchcraft and voodoo practices and had nightmares. This was not explored, and a possible assumption was made again that this was part of religious or cultural practices.

Learning

- Nurturing professional curiosity and challenge are fundamental aspects of working together to keep children and young people safe. There is a need to always apply professional curiosity and triangulate information from all sources to form a working hypothesis.
- Clarifying and verifying information is important. The family situation was complex and it was hard to understand who provided care for the children and who was a relative. It is important for primary care practitioners to be curious and think about how to engage with other professionals involved with the family.

[11] https://ueaeprints.uea.ac.uk/id/eprint/72448/1/Accepted_Manuscript.pdf

- Practitioners can use supervision and multiagency meetings to think about their own judgements and observations. This could include thinking about what support the family would need rather than viewing the role of the father in isolation. There were indicators that the father was experiencing anxiety about his relationship and becoming a father of twins.
- Professionals need to think about how to make active enquiries about a child's father, the mother's relationships and any adults in contact with the child. These details need to be recorded.
- In some cultures, there might be additional barriers that prevent mothers from opening up and discussing their partners' involvement in their children's lives. Practitioners need to build understanding about the way different communities and cultures perceive domestic abuse and how women view the role of health services. Supervisors should support practitioners to find ways to engage with mothers and build trust.

Information sharing

50. Information sharing was not helped in this case by a number of factors. Midwives in Dudley do not have access to a system known as Badgernet[12] unlike Sandwell which allows access to real time maternity information. There are plans to ensure that health visitors, school nurses and community midwives will all have access to the GP EMIS system shortly.

51. Health visitors did not have access to school health records. School nurses are commissioned by Shropshire Local Authority and this created a potential barrier in communication.
52. The health visitors did not follow up with social care or link with school nurses, even though they knew that Child YS had older siblings who had previous social care input.
53. Clear and factual record keeping is important. Previous history reported by the mother about the half siblings' contact with social care was not documented fully in maternity records. There was no subsequent follow up with social care to verify information.
54. Accuracy is vital and inaccurate recording of information is detrimental to outcomes for children and families.

[12] Patient Data Management Information Provides a complete platform solution for the collection, storage, and reporting of live perinatal patient data

55. Importance of information held in parents' primary care records cannot be overstated. Often it is the GP who may have the most contact with a family. In this case, it was the father's GP who had vital history and knowledge of his mental health and well-being and had recent information about his relationship with Child YS's mother. As there is often no system link between GP practices across boundaries, this relies on the practitioner to be curious and to dig deeper. It highlights the need for professional curiosity and improved multi-agency practice. This might have involved seeking consent from the father for the GP to share information with the health visitor or midwife and looking at ways of offering the family support. Further follow-up by the GP or another practitioner to review the father's mental health and well-being would have been helpful.
56. Short appointment slots and busy schedules in primary care do not always allow for opportunities to probe, highlighting the need for professional curiosity and multi-agency practice.
57. In June 2020 the Child Safeguarding Practice Review National Panel announced a new national thematic review which will look at non-accidental injury in children under one, which will also explore working with fathers.
58. 'Hidden Fathers' is now the subject of a number of CSPRs. It has been identified that males involved with children may be able to offer support and be considered to be protective factors but that they may also pose risk to children. This cannot be verified unless practitioners explore the family dynamics.
59. In this case, the father's presence in the family was not understood and in spite of questions from the health visitor the mother did not wish to disclose the father's details. However, he was known to primary care services and did attend at least one of the twins' immunisation appointments at the GP Surgery with mother. He was also known to his GP.
60. The fact that the mother and father had separate GPs added to the difficulties in gathering and sharing information. This is not uncommon and has been the feature of a number of Rapid Reviews.
61. Participants in the learning event suggested that GP receptionists could consider asking about any change of address as part of routine booking in. Most GP Practices use an electronic booking-in system and therefore this will need careful consideration.

Learning

- As noted earlier, triangulation is necessary to establish the facts, gather evidence and inform decision making. The origins of information, such as self-reporting, should also be recorded and whether it has been possible to check and confirm the accuracy. Practitioners should be alert to whether assumptions are being made about a family.

- Working with the multl-disciplinary team is necessary to enable GPs to share information and concerns. Learning from working during the COVID-19 pandemic means that it should now be easier and more accessible for practitioners to meet together virtually.
- Badgernet is used by many maternity services and improves access to real time information. It is used in Walsall, Wolverhampton and Sandwell but not Dudley.
- Health visitors need access to EMIS to improve communication.
- Schools are a safe and stable environment for children. The school had information that no other agency had access to, such as the half sibling's references to witchcraft and voodoo. This was not explored. They had also been trusted by the mother's sibling who disclosed intrafamilial domestic abuse and that there was 'control' in the family.

Creating space for multiagency reflection

62. Creating space for multiagency reflection is about leading a quality culture in safeguarding at a systems level. At the heart of this is the need to build a system that promotes professional judgement. This means that systems will need to be better at monitoring, learning, and adapting their practice. DSPP and SCSP will need to consider a range of methods for assessing quality and showing evidence of impact in practice.
63. The use of effective supervision is a means of improving decision-making and accountability. Group supervision and reflective discussions can be even more effective in promoting curiosity, peer learning and safe uncertainty.
64. New information was given to the schools, for example when a family member expressed concerns that maternal grandmother of Child YS was controlling. This was a trigger for reflection and review and a time to pause and triangulate information.
65. The schools played a pivotal role in the gathering of information and forming hypotheses about the family dynamics and the two schools involved shared information. They state they were not aware that mother had a new partner or about the twins' birth. However, in her conversation with the author, mother stated that the teachers were aware and that the maternal half siblings were excited about the arrival of twins.
66. The schools had a sense of growing unease and started to put together a genogram. There was no referral to Children's Services via a multiagency referral form (MARF), or consideration of a professionals' meeting. The schools need to reflect on how to escalate concerns via a professionals' multi-agency meeting.

67. Agencies need to have an understanding of thresholds and an awareness of different roles and responsibilities across the DSPP and SCSP.
68. Genograms are a useful tool and health visiting services and Sandwell Children's Trust are now using them – these need to be widely used across partner agencies. The use of genograms is good practice and needs to be part of a triangulation process to support analysis. It is important to use the most appropriate genogram such as the three generational cultural genograms.
69. Supervision in schools is a requirement and all schools have a designated safeguarding lead (DSL). This was a case where the intervention of a DSL would have been helpful as would reflective supervision.
70. School nursing had been involved previously when the maternal half siblings were on a Child Protection Plan. The health visiting service were aware of the older children but did not explore this with the school nursing service. This should have prompted a professionals' meeting with the school to share information and look at options for further action.
71. There are a range of methodologies for reviewing cases such as the Problem Tree (or situational analysis), Signs of Safety, and Kolb's reflective learning cycle[13].

Learning

- Quality assurance, oversight and challenge of practice are interlinked. The Quality Assurance Frameworks should clearly outline vision, values and principles that drive learning. This should ensure that safeguarding work responds to current challenges and most importantly the lived experience of children.
- Leading a quality culture[14] should embrace the following key areas:
    - Vision, values, commitment to quality
    - Policies, procedures and processes
    - Standards
    - Equipped workforce
    - Quality assurance, monitoring, review and learning activities
    - Approaches to quality improvement and learning cultures

[13] Kolb: Kolb D (1984) *Experiential Learning: Experience as a source of learning and development*. New Jersey: Prentice Hall

Signs of Safety: https://www.signsofsafety.net/signs-of-safety/

Problem Tree: http://www.mspguide.org/tool/problem-tree

[14] Seminar from Research in Practice in the States of Guernsey Jan 2021

    - A whole systems approach – high challenge/high support
- Building a quality culture in safeguarding is imperative and creates an environment in which multi-agency practice will flourish, including greater professional curiosity and working together.
- A case discussion tool that uses effective evidence-based methodologies would support actions and learning for the system that are grounded in the lived experience of the child. This would promote understanding and build a strengths-based and outcome-focussed approach.
- We know that supervision is a vital tool to support safe and reflective practice, and multiagency supervision is useful to test out hypotheses and assumptions. It is useful to pull a meeting together when there is a sense of confusion and unease.
- Keep the children's lived experience at the centre of all discussions. This should focus entirely on understanding about the child, their characteristics, who their family is and what we understand that life is like for them.
- Agencies should understand each other's roles and thresholds.
- Every agency is responsible for identifying and implementing its own learning in addition to multi-agency learning.

Cultural awareness and assumptions

72. Many assumptions were made about family traditions and cultural diversity. It was considered a good thing that the mother was living with extended family and that this was a normal part of Asian or Muslim culture. This became a barrier and stifled further questioning about the children living in the household.
73. The maternal half siblings had reportedly spoken about voodoo and witchcraft and had nightmares. This was not explored with the mother or wider family who were known to be caring for the half siblings.
74. Different maternal family members collected the maternal half siblings from school over the years alongside other children in the family.
75. The Child Protection Plan for the maternal half siblings was discontinued once their parents had separated and domestic abuse reportedly ceased. However, their father continued on occasions to have contact via school and requested to give them presents for Eid.
76. In the learning events, comments were made about mother and her sister being 'Westernised' and that this caused tension in the family. This was not just an assumption about family traditions and culture, but also stereotypes of Asian women.

77. A picture emerges of a complex family dynamic in which the thread of trauma is evident in both the lived experience of the half siblings and mother. In her conversation with the author, mother said that she did not disclose domestic abuse to professionals because of fear that this would not be kept confidential and would somehow get back to the father or the paternal grandparents. She referred to the incident as an attempted 'honour killing'[15] and spoke of how the paternal grandparents of Child YS were ashamed of her as she been married previously.
78. Creating a safe space for women to disclose is vital and in particular in health settings. There will need to be careful consideration to explore ways of ensuring that women from Asian communities trust that information will not be divulged.
79. Black Country Women's Aid estimate that South Asian women may take an extra 10 years before they seek help and therefore children often remain in unhealthy households for a prolonged period.

"In South Asian communities they fear disclosures of domestic violence arising from the notion of shame, honour, racism and lack of awareness[16]."

80. There are two family lines of inquiry: the father's family and the mother's family. Little information was known about the father and his background but there was information about the mother's family.
81. Assumptions were made about extended families living together and that this was normal practice in the Asian community. This assumption may have prevented practitioners visiting the home from asking more challenging questions about family and childcare.
82. Professionals need to exercise real professional curiosity and use their own professional initiative – as one practitioner said 'make it our business' to understand family traditions and diversity.
83. Professionals should recognise that different families from the same cultural or religious group may have different views and practices. They should recognise the importance of asking individuals and families about what matters to them and challenge assumptions.

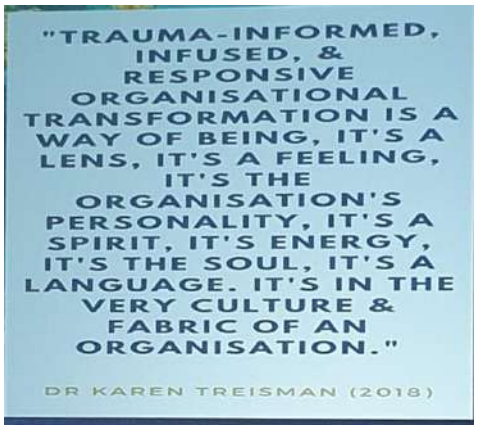
[15] **Honour based violence** is a violent crime or incident which may have been committed to protect or defend the perceived honour of the family or community. It is often linked to family members or acquaintances who mistakenly believe someone has brought shame to their family or community by doing something that is not in keeping with the traditional beliefs of their culture.

[16] *Source NSPCC - Campaign Briefing 5 Children experiencing domestic violence in South Asian Communities*

Learning

- DSPP and SCSP should work with faith communities to raise awareness of the need for neighbours and communities to support women and report domestic abuse.
- Both safeguarding partnerships should link with the Black Country Women's Aid IDVA service and other organisations such as the Muslim Women's Network to understand the prevalence of domestic abuse in different faith communities and what support is available.

Trauma informed and trauma aware



84. Trauma informed systems acknowledge that every interaction is an intervention and relationships are at the core of the work. Trust is at the heart of this approach. Lencioni[17] refers to this as vulnerability based trust: that is, the ability to have a relationship with a family, client or colleague based on honesty and the ability to challenge and manage conflict and integrity.
85. This does not preclude the need to provide critical challenge and have honest conversations. Bruce D Perry[18] refers to trust as 'the currency for systemic change'. This requires an equipped workforce with an understanding of trauma informed ways of working.
86. Trauma informed systems prepare people to reflect and not react. The journey to becoming trauma informed begins with being trauma sensitive and aware.
87. All of the children in this family have experienced adverse childhood experiences (ACEs) and will require support. The long-term impact of childhood exposure to domestic violence and abuse has been well-documented. The most significant risk of long-term harm is found in children who are exposed to domestic abuse during infancy. This can harm the development of the brain and impair cognitive and sensory growth.
88. The mother of Child YS has experienced significant trauma as a result of domestic abuse. She is experiencing flashbacks and is struggling to make sense of what happened. From a trauma informed perspective we can potentially see signs of 'shut down' with professionals in that she did not feel able to disclose and answer honestly

[17] 5 behaviours of a cohesive team Patrick Lencioni

[18] — Bruce D. Perry, The Boy Who Was Raised As a Dog: And Other Stories from a Child Psychiatrist's Notebook

to the routine enquiry questions. In some ways, this is similar to Judith Herman's[19] description of 'psychic numbing' as a disempowerment and disconnection from others through experience of trauma.

Learning

- There is a large evidence base surrounding the links with ACEs and trauma and their long-term impact on the health and wellbeing of children and families.
- It is important to raise awareness of ACEs as a foundation for continuing to develop trauma informed approaches.
- Recognising the complexity of this task and moving to a trauma informed approach requires a whole system response.

'It is well known that the effect of childhood trauma and adversity can be moderated by strong, stable relationships and that poor outcomes following childhood trauma are not inevitable. In order to transform the lives of infants, children, and young people we need to transform the lives of the adults who take care of them. This will involve a whole system approach with action at various levels to both strengthen the case for early intervention and prevention as well as working together to support adults, who may be experiencing adversity to improve outcomes for the whole family.' – **The State of Child Health: Adversity is not Destiny – Developing a Trauma Informed Approach across Ayrshire and Arran, October 2019**

Reflective points for the SCSP and DSPP to consider:

- *How can the partnerships influence the necessary cultural and systemic changes across all partner agencies in terms of trauma informed approaches?*
- *How will the partnerships be assured that agencies are working together to improve joint reflection on cases?*
- *How will the partnerships embed and monitor understanding of cultural diversity?*
- *How will the SCSP and DSPP be assured that people are doing what they should be doing rather than a focus on operational elements of each agency/partner?*

Summary

89. The need to build robust quality assurance into safeguarding is essential. There should be a culture of continuous learning and improvement across agencies working together to safeguard and promote the wellbeing of children.

[19] Judith Herman (1992) Trauma and Recovery

90. This is a complex family situation and while we can pull out learning across the system it is not possible to conclude that this would have alerted professionals to a potential serious incident. However, had information held by services been shared then there might have been greater curiosity about the father of Child YS.
91. Professionals have good intentions when working with families. Sometimes, cultural practices, systems and processes lead to poor decision-making and information sharing.
92. Underpinning this review is the need for professional curiosity and 'digging deeper'. It points to the need to seek out multi-agency views when there is 'unease' or concern. This should complement supervision processes and is not a replacement.
93. Improvements are planned to improve information sharing in maternity services and enabling EMIS information sharing between midwifery, school nursing, health visiting and GP practices in Dudley.
94. The School Nursing service will transfer to Dudley Council in April 2021 and this is an opportunity to improve pathways and strengthen the safeguarding offer. This should include a spotlight on the transition between health visiting and school nursing.
95. The use of genograms by the schools in Dudley was good practice. However, a standardised approach for culturally competent 3 generational genograms would be beneficial in both Dudley and Sandwell.
96. Health visiting services have now introduced training to ensure that genograms are used effectively and this should include the same 3 generational cultural genogram to be completed with families.
97. Engagement with fathers is highlighted in many reviews. However, this requires information about the father and in this case there was no triangulation between midwifery in Dudley, who had the father's details as an emergency contact, and health visiting. The father was registered with a GP in Sandwell which made this more challenging.
98. The challenge of cross border working featured in this review. The mother moved between Dudley and Sandwell, but no agency was aware that this was happening as recorded addresses did not change.
99. Hindsight bias is powerful and actions that should have been taken in the time leading up to an incident can seem obvious because all the facts become clear after the event.

What hindsight does is it blinds us to the uncertainty with which we live. That is, we always exaggerate how much certainty there is. Because after the fact, everything is explained.

Everything is obvious. And the presence of hindsight in a way mitigates against the careful design of decision making under conditions of uncertainty." — Daniel Kahneman

Recommendations

Discussion with partners identified common learning themes for both Dudley and Sandwell.

1. The SCSP and DSPP should seek assurance that there is effective information sharing across health services as outlined in the single agency action plan, in particular between Primary Care, Midwifery, Health Visiting and School Nursing. This should include when sharing information across boundaries.
2. The SCSP and DSPP should seek additional evidence that there is a 'Think Family' approach in the above named health services and contact with fathers is documented and recorded.
3. The SCSP and DSPP should gain assurance that all agencies are using evidence-based tools, such as those referred to in the report, to inform assessments and analysis.
4. The DSPP and SCSP should have training in place on effective safeguarding of children from Black and Minority Ethnic, Cultural and Faith Communities to include understanding barriers and challenges that may impact on engagement.
5. The SCSP and DSPP should work with the Domestic Abuse Strategic Partnership, Black Country Women's Aid, and other organisations such as the Muslim Women's Network and other community groups, to promote awareness of the need for neighbours and families to report domestic abuse and develop community resilience.
6. The DSPP and SCSP should seek to develop a shared understanding of trauma informed practice and ACEs with its partner organisations and explore good practice in other areas, such as NHS Scotland, to develop a training framework. The partnerships should also:

a) Consider a leadership statement to show commitment to becoming a trauma informed partnership.
b) Create a forum for sharing and developing trauma informed practices including from other areas.
c) Develop a set of resources to promote trauma informed practice. This will lead to the development and use of multiagency policies and supervision strategies that are restorative and transformational.

7. The DSPP should seek assurance that schools and partner agencies are familiar with and use the Resolution and Escalation policy in cases where they feel ‘stuck’.

As a result of the above recommendations an action plan will be developed and the DSPP and SCSP will ensure that learning is widely disseminated, and actions are implemented.